CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 5: DENIALS, GRIEVANCES, AND APPEALS

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# 5.5 Medical Necessity Denials

## Introduction

When a determination is made to not authorize a service, the denial could be either for medical necessity or benefit related. This section includes information on medical necessity denials. Please see the applicable section in this unit for benefit denials.

## Physician Reviewer

When a provider requests authorization for an admission or a service, but it is determined that the applicable medical necessity criteria are not met, the case is forwarded to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact medically necessary, an authorization is issued.
- If the physician reviewer agrees with the initial assessment that the service is not medically necessary, a medical necessity denial is issued. Only a physician can render a denial as not medically necessary.

This process applies whether the authorization request was submitted through NaviNet® or initiated by telephone contact with Clinical Services.

## Behavioral Health Review Process

When Highmark Behavioral Health Services makes the initial assessment that a member’s case does not meet the applicable medical necessity criteria, alternative levels of care may be discussed with the requesting provider. If these suggestions are not acceptable to the treating physician or the facility, the behavioral health care manager refers the case to a physician reviewer:

- If the physician reviewer disagrees and determines that the service is in fact medically necessary, an authorization is issued.
- If the physician reviewer’s decision is to not authorize the services, a verbal notice of non-authorization is given to the provider, and a written notice follows within one (1) business day after the verbal notice.

## Written Notification of Denial

Providers are notified verbally, as well as formally by letter, when the decision is made to not authorize a service. NaviNet®-enabled providers also receive denial notifications through the Referral/Authorization Inquiry transaction.

*Continued on next page*
5.5 MEDICAL NECESSITY DENIALS, Continued

Content of denial letter

As required by regulatory and accrediting agencies, denial letters contain very specific information, including the following:

- Identification of the denied service(s) and service date(s), when applicable
- Clinical rationale that provides a clear and precise reason for the decision
- Utilization criteria, medical policy, or benefit provisions used in making the adverse determination
- A statement that a copy of any policy, criteria, guideline, or other information referenced is available upon request (not applicable to Medicare Advantage)
- Suggested alternative level of care, if appropriate
- Suggested alternatives for treatment, if benefits are exhausted
- Information about member and provider appeal rights and the process to initiate an appeal

Financial responsibility agreement

In accordance with Highmark’s policy on denials for medical necessity reasons (including clinical appropriateness as to site of service) or any non-covered services, the member cannot be billed unless he or she has specifically agreed in writing, in advance of the service, to be financially responsible for the entire expense. This financial responsibility agreement must specify the procedure to be performed and include an estimate of the cost of the procedure.

Note: The general waiver document routinely signed by patients at admission or registration is not sufficient for this purpose.
5.5 BENEFIT DENIALS

**Benefit verification is provider responsibility**

It is the responsibility of the provider to verify that the member’s benefit plan provides the appropriate benefits before rendering a service. The NaviNet Eligibility and Benefits Inquiry transaction provides the information needed to make this determination.

If NaviNet is unavailable, providers can contact the Highmark Provider Service Center for information about benefits for medical services, or Highmark Behavioral Health Services for information about benefits for behavioral health services.

**Notification of denial**

When authorization requests are submitted by telephone contact, the care manager can assist the provider by verifying whether the member’s benefit plan provides the specific benefit for the service to be rendered.

If, in fact, the member does not have the benefit, the care manager notifies the provider verbally and follows up with a benefit denial letter.

**Member’s right to appeal**

Although the provider is not permitted to appeal a benefit denial, the member can do so. The benefit denial letter addressed to the member provides the information needed to initiate the appeal.
5.5 PEER-TO-PEER CONVERSATION

**Purpose**

The purpose of the peer-to-peer conversation is to allow the ordering or treating provider an opportunity to discuss a medical necessity denial determination. This process is typically initiated when a peer-to-peer conversation did not occur prior to the initial denial determination.

**Peer-to-peer option offered at time of denial notification**

Highmark will advise the treating provider of the availability of this process for commercial members when verbally notifying the provider of an authorization denial (if a peer-to-peer conversation has not already occurred). This discussion may help resolve the issue and spare the time and expense of an appeal.

*Note:* If the provider chooses to proceed with an appeal, the peer-to-peer option is forfeited and no longer available to the provider.

**IMPORTANT!**

The peer-to-peer conversation option is **not available** for Medicare Advantage members.

**Process**

The provider has **two (2) business days** after notification of an authorization denial to initiate a peer-to-peer review for commercial members. The provider may initiate the peer-to-peer conversation by calling the dedicated peer-to-peer phone line. The peer-to-peer conversation will be made available **within one (1) business day** after receiving a request.

If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case. In the event the peer-to-peer conversation does not result in an authorization, the provider and member will be informed of their appeal rights and procedures.

**Initiating a peer-to-peer conversation**

To initiate a peer-to-peer conversation, the provider should call the dedicated peer-to-peer toll-free phone number: **1-866-634-6468**. Hours of operation are from 8:30 a.m. to 4:30 p.m. (EST), Monday through Friday.

Providers are encouraged to call during hours of operation to speak with a live intake agent who will gather the necessary information and answer any questions. Requests will then be forwarded to the Highmark clinical peer reviewer who made the determination (or an appropriate designee).

Continued on next page
### 5.5 PEER-TO-PEER CONVERSATION, Continued

**Initiating a peer-to-peer conversation (continued)**

If an emergent need arises before or after business hours, the option to leave a voicemail message is available. The following information will be needed:

- CASE/REQ# (e.g., REQ-1234).
- Patient’s name and Member ID.
- Name of the treating and/or ordering provider requesting the peer-to-peer conversation and the phone number where a Highmark clinical peer reviewer can reach the provider.

The Highmark clinical reviewer will contact the provider within one (1) business day from the time of the request.

**Outcomes of peer-to-peer conversation**

If the peer-to-peer conversation or review of additional information **results in an approval**, the physician reviewer informs the provider of the approval.

If the conversation **does not result in an approval**, the physician reviewer informs the provider of the right to initiate an appeal, and explains the procedure to do so.

**naviHealth peer-to-peer conversations**

Peer-to-peer conversations should be requested directly from naviHealth for authorization requests for skilled nursing, long-term acute care, and inpatient rehabilitation services for Medicare Advantage members.

To initiate the process, the provider should contact naviHealth via their toll-free telephone number **1-844-838-0929**.
5.5 PROVIDER APPEALS

Overview

Highmark follows an established appeals/grievance process as a mechanism for providers to appeal an adverse benefit determination. This section will describe the specific processes as they apply to providers appealing on their own behalf for services provided to Highmark members. Please see the Medicare Advantage: Provider Appealing On Own Behalf section of this unit for Medicare Advantage members.

A provider may appeal a medical necessity denial decision, including decisions to deny experimental/investigational or cosmetic procedures. At the time of a denial determination, the provider is informed of the right to appeal and the process for initiating an appeal.

Note: In Delaware, the provider appeal processes outlined here apply only to providers participating in Highmark Delaware’s provider networks.

Applicable products

The provider appeal processes described here apply to all Highmark members except those with coverage under Highmark’s Medicare Advantage products, the Federal Employee Program (FEP), or products sold on the Marketplace Exchange.

- For the provider appeal processes applicable to Medicare Advantage products, please see content later in this unit.
- For information regarding the Reconsideration and Appeal process for FEP, please contact FEP Customer Service:
  - Pennsylvania: 1-866-763-3608
  - Delaware: 1-800-721-8005
  - West Virginia: 1-800-535-5266
- For information regarding appeals in Pennsylvania, Delaware, and West Virginia related to Affordable Care Act (ACA) regulated, under 65 on-exchange products, please call the customer service phone number on the back of the member’s identification card.

Initiating an appeal

Requests for appeals may be submitted either by telephone or in writing.

A provider has one-hundred eighty (180) days from the date of the initial denial of coverage in which to file an appeal in all of Highmark’s service areas in Pennsylvania, West Virginia, and Delaware (PA CHIP exception below).

CHIP filing time frame

For the Children’s Health Insurance Program (CHIP) in Pennsylvania, a provider has sixty (60) days from the date of the initial denial of coverage in which to file an appeal.

Continued on next page
5.5 PROVIDER APPEALS, Continued

Types of provider appeals

There are two types of appeals available to the provider following a medical necessity denial – expedited appeal or standard appeal. The type of appeal is determined by the urgency of the situation, as well as the physician’s assessment of the situation.

Explicit directions for filing appeals appear in the written denial notification, which is sent to the member or the member’s representative and the physician and/or facility, as appropriate. This process involves a verbal or written request initiated by the provider to review a determination that denied payment of a health care service for medical necessity. A clinical peer reviewer who was not involved in the original denial must conduct the review.

Expedited appeal

An expedited appeal is used when a member is receiving an ongoing service or a member is scheduled to receive a service for which coverage has been denied, but the treating provider believes that a delay in service will adversely affect the member’s health. This process may be used when any of the following circumstances exist:

- A delay in decision making might jeopardize the member’s life, health, or ability to regain maximum functions based on a prudent layperson’s judgment and confirmed by the treating practitioner; or
- In the opinion of the practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or
- Concerning the admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; or
- Concerning a concurrent review.

Standard appeal

A standard appeal is used for preservice denials in non-urgent situations and also for appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.

It is also used as a secondary appeal level when a denial is upheld under the expedited appeal process. In West Virginia and Delaware, provider appeal rights are exhausted after the standard appeal.

Continued on next page
5.5 PROVIDER APPEALS, Continued

Highmark’s appeal review process follows all applicable accreditation requirements. These include the following components:

- Review by a clinical peer reviewer who is board certified and holds an unrestricted license and is in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.
- Reviewer is neither the individual who made the original decision nor the subordinate of such individual.
- Review of the appeal within time frames established by the applicable regulations and standards.
- Verbal (as applicable) and written communication of the decision within time frames established by the applicable regulations and standards.

Responsibility for medical treatment and decisions

Under all circumstances, the member and the physician bear ultimate responsibility for the medical treatment and the decisions made regarding medical care. Providers and Highmark employees involved in utilization management decisions are not compensated for denying coverage nor are there any financial incentives to encourage denials of coverage.
5.5 EXPEDITED PROVIDER APPEAL PROCESS

This process applies in situations where decisions need to be made in an urgent manner prior to services being rendered or for continued stay decisions following a concurrent review denial. All concurrent service appeals are considered urgent.

Note: The expedited appeal process is not applicable when the service has already been rendered.

**EXPEDITED PROVIDER APPEAL PROCESS**

<table>
<thead>
<tr>
<th>How to Initiate</th>
<th>Contact Clinical Services to initiate an expedited appeal. Clinical Services may request additional information to be faxed if needed.</th>
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<tbody>
<tr>
<td></td>
<td>- Pennsylvania:</td>
</tr>
<tr>
<td></td>
<td>- Western Region Facilities: <strong>1-800-242-0514</strong></td>
</tr>
<tr>
<td></td>
<td>- Western Region Professional Providers: <strong>1-800-547-3627</strong></td>
</tr>
<tr>
<td></td>
<td>- Central Region Facilities: <strong>1-866-803-3708</strong></td>
</tr>
<tr>
<td></td>
<td>- Central Region Professional Providers: <strong>1-866-731-8080</strong></td>
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<tr>
<td></td>
<td>- Northeastern Region: <strong>1-800-452-8507</strong></td>
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<tr>
<td></td>
<td>- Delaware:</td>
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<tr>
<td></td>
<td>- For IP/OP medical requests: <strong>1-800-572-2872</strong></td>
</tr>
<tr>
<td></td>
<td>- For IP/OP behavioral health requests: <strong>1-800-421-4577</strong></td>
</tr>
<tr>
<td></td>
<td>- West Virginia: <strong>1-800-344-5245</strong></td>
</tr>
</tbody>
</table>

| When to Initiate | Prior to the member’s discharge from the facility or before rendering services, but within the applicable time frame from receipt of the denial notification. |

The expedited appeal must be initiated within one hundred eighty (180) days from receipt of the denial notification in all of Highmark’s service areas in Pennsylvania, West Virginia, and Delaware. **NOTE:** The time frame is within sixty (60) days of receipt of the denial notification for Pennsylvania CHIP.

| Decision Time Frame | As expeditiously as the member’s health requires, but **not to exceed seventy-two (72) hours** from receipt of the appeal request, a decision is rendered to uphold or reverse the original denial. |

**Note:** For Act 68 expedited appeals in Pennsylvania, the decision time frame is **not to exceed forty-eight (48) hours.** Please refer to the section later in this unit titled “Expedited Grievance: Filing On Behalf of a Member (PA Act 68)” for additional information.

Continued on next page
5.5 EXPEDITED PROVIDER APPEAL PROCESS, Continued

**Notification of decision**
The appropriate parties will be notified of the determination by telephone, followed by written notification. Written notification will include, but not be limited to, the following information:

- Reason/clinical rationale for an adverse determination
- Source of the criteria used to make the determination
- Right to file a standard appeal and the procedure to initiate it
5.5 STANDARD PROVIDER APPEAL PROCESS

Introduction

This process applies to preservice denials in non-urgent situations and also to appeals of a post-service denial decision, including denials resulting from retrospective reviews of services rendered without the required authorization.

Requests for standard appeals may be submitted either by telephone or in writing.

When to initiate

A provider must file an appeal within one hundred eighty (180) days from receipt of the denial notification in all of Highmark’s service areas in Pennsylvania, West Virginia, and Delaware.

NOTE: The time frame is within sixty (60) days of receipt of the denial notification for Pennsylvania CHIP.

Appeal process

The following process is followed for standard provider appeals:

1. The provider submits a request to appeal an adverse medical necessity decision either by calling Clinical Services or in writing to the applicable mailing address (indicated below).

2. A Clinical Services care manager will contact the provider if any additional information is needed to conduct the review and the provider sends it to the Clinical Services care manager.

3. A clinical peer reviewer who was not involved in the original denial decision reviews the case.

4. The provider is notified of the decision by telephone within thirty (30) calendar days of receipt of the request and all pertinent information. Written notification is sent to the provider and the member.

To initiate by telephone

To initiate a standard provider appeal by phone, contact Clinical Services by calling the applicable telephone number for your service area:

**PENNSYLVANIA:**
- Western Region Facilities: 1-800-242-0514
- Western Region Professional Providers: 1-800-547-3627
- Central & Northeastern Region Facilities: 1-866-803-3708
- Central & Northeastern Region Professional Providers: 1-866-731-8080

**DELAWARE:**
- For IP/OP medical requests: 1-800-572-2872
- For IP/OP behavioral health requests: 1-800-421-4577

**WEST VIRGINIA:** 1-800-344-5245

Continued on next page
### 5.5 STANDARD PROVIDER APPEAL PROCESS, Continued

**Mailing addresses**
Submit all pertinent information for to the applicable address below for Commercial appeals. Please see the [Medicare Advantage: Provider Appealing On Own Behalf](#) section of this unit for Medicare Advantage members.

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<th>POST-SERVICE APPEALS</th>
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<tr>
<td><strong>Pennsylvania:</strong></td>
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<tr>
<td><strong>Western Region</strong></td>
<td>Highmark</td>
<td>Highmark</td>
</tr>
<tr>
<td>(all providers)</td>
<td>120 Fifth Avenue</td>
<td>Medical Review</td>
</tr>
<tr>
<td></td>
<td>Suite P4301</td>
<td>P.O. Box 890392</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222</td>
<td>Camp Hill, PA 17089-0392</td>
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<td><strong>Pennsylvania:</strong></td>
<td>Professional Providers:</td>
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<td><strong>Central, Eastern, &amp; Northeastern Regions</strong></td>
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<td>Attn: Appeals</td>
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<td></td>
<td>P.O. Box 890035</td>
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<td>Camp Hill, PA 17089-0035</td>
<td>Camp Hill, PA 17089-0035</td>
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<td></td>
<td>Pittsburgh, PA 15222</td>
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<tr>
<td><strong>Delaware</strong></td>
<td>Highmark BCBSDE, Inc. Medical Management Appeals</td>
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<td>(all providers)</td>
<td>P.O. Box 1991</td>
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<td><strong>West Virginia</strong></td>
<td>Highmark West Virginia</td>
<td>Highmark West Virginia</td>
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<tr>
<td>(all providers)</td>
<td>Attention: Appeals Committee</td>
<td>Attention: Medical Review</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 535095</td>
<td>P.O. Box 1948</td>
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<td></td>
<td>Pittsburgh, PA 15253-5095</td>
<td>Parkersburg, WV 26102</td>
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<td><strong>Behavioral Health Services</strong></td>
<td>Highmark Clinical Services</td>
<td>Retro Reviews/Standard Commercial Appeals: Utilization Management</td>
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<td>(all service areas)</td>
<td>Attn: Behavioral Health</td>
<td>Attention: Review Committee</td>
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<tr>
<td></td>
<td>120 Fifth Avenue, Suite P4205</td>
<td>120 Fifth Avenue, Suite P4104</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222</td>
<td>Pittsburgh, PA 15222</td>
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What Is My Service Area?
5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER

Overview

Any Highmark member has the right to appeal an adverse determination if they are not satisfied with decisions made by Highmark regarding the coverage of services. There are specific federal and state laws and regulations that guide the member appeal process.

Highmark will resolve member appeals in a thorough, appropriate, and timely manner in accordance with the Department of Labor (DOL) Claims Procedure Rule under the Employee Retirement Income Security Act of 1974 (ERISA) and the requirements imposed under the Affordable Care Act (ACA).

The DOL appeal process applies to all group health plans governed by ERISA regardless of whether the group is fully insured or self-funded. Highmark also applies this process to all non-ERISA group accounts.

Definition of a member appeal

A member appeal is a request from a member, or member’s authorized representative or a provider (with the member’s written consent), to review an adverse benefit determination.

This includes services related to coverage, which include contract exclusions, non-covered benefits, and decisions related to the medical necessity and/or appropriateness of a health care service. This also includes full or partial adverse benefit determinations involving a requested health care service or claim.

This process applies to both pre-service and post-service appeals.

Submitting an appeal on behalf of the member

The appeal may be submitted verbally or in writing and should include supporting documentation. Unless requesting an expedited appeal, the following forms must be completed to submit an appeal request in writing:

- Pennsylvania and West Virginia: Designation of an Authorized Representative
- Delaware: Designation of Personal Representative for Appeal Processes

These forms can be found on the Provider Resource Center in your service area. Select FORMS from the main menu, and then Miscellaneous Forms.

If the member appoints a provider as his personal representative, the member may not submit his own appeal concerning the services listed in the Designation form. The member may rescind his Designation (must be in writing) at any time during the process.

Continued on next page
**5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER**, Continued

**Filing time frame**
The appeal must be filed no later than **one-hundred eighty (180) days** after receipt of the original denial notification.

**Verbal requests**
To submit an appeal request verbally, please contact Highmark by calling the Member Service telephone number on the back of the member’s ID card.

**Written requests**
Written appeal requests for Commercial members can be mailed to the appropriate address below. Please see the *Medicare Advantage: Appeals On Behalf of A Member* section of this unit for Medicare Advantage members.

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<thead>
<tr>
<th>PENNSYLVANIA:</th>
<th>CENTRAL REGION:</th>
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<tr>
<td><strong>Western &amp; Northeastern Regions:</strong></td>
<td><strong>Central Region:</strong></td>
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<tr>
<td>Member Grievance &amp; Appeals</td>
<td>Highmark Blue Shield</td>
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<tr>
<td>Attn: Review Committee</td>
<td>Attn: Review Committee</td>
</tr>
<tr>
<td>P.O. Box 535095</td>
<td>P.O. Box 890178</td>
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<tr>
<td>Pittsburgh, PA 15253-5095</td>
<td>Camp Hill, PA 17089-0178</td>
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<th>DELAWARE:</th>
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<tr>
<td>Highmark Blue Cross Blue Shield Delaware</td>
</tr>
<tr>
<td>Attn: Customer Service Appeals Team</td>
</tr>
<tr>
<td>P.O. Box 8832</td>
</tr>
<tr>
<td>Wilmington, DE 19899-8832</td>
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<table>
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<tr>
<th>WEST VIRGINIA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highmark West Virginia</td>
</tr>
<tr>
<td>P. O. Box 1988</td>
</tr>
<tr>
<td>Parkersburg, WV 26101</td>
</tr>
</tbody>
</table>

**FEP members**
For member appeals and reconsiderations for the Federal Employee Program (FEP), please contact **FEP Customer Service** for your service area:

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266**

*Continued on next page*
5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

Letter acknowledging receipt
An acknowledgement letter will be sent to the member or to the provider filing on behalf of the member **within five (5) business days** from receipt of the request. The letter will include:

- A description of the appeal process.
- A statement affording the opportunity for the member to submit written comments, documents, or other information relating to the appeal.
- A statement advising that the member, or the member’s representative filing on behalf of the member, may have access to information related to the appeal upon request or may submit additional material to be considered.

Medical necessity appeals
Any appeals related to medical necessity issues are reviewed by a licensed provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment of the service being appealed. The health care provider will not have been involved in any previous adverse benefit determination regarding the subject of the appeal or be a subordinate of any individual that was involved in the adverse benefit determination.

Benefit related appeals
Appeals regarding benefit denials do not require clinical review. The appeals analyst will determine whether the benefit was applied correctly under the applicable benefit program.

Decision time frame
In Pennsylvania and West Virginia, the member and the provider filing on behalf of the member will be notified of the decision in writing **within thirty (30) calendar days** from receipt of the request.

In Delaware, the member and the provider filing on behalf of the member will be notified of the decision in writing **within thirty (30) calendar days** from receipt of the request for preservice appeals, and **thirty to sixty (30-60) calendar days** for post-service appeals.

Decision letters will provide information on any additional appeal rights that are available.

*Continued on next page*
5.5 FILING AN APPEAL ON BEHALF OF THE MEMBER, Continued

**Urgent appeals**

A request for an **urgent review** of a previous adverse benefit determination for medical, pharmaceutical, or behavioral health services on the basis of medical necessity and appropriateness may be filed by a member, member’s authorized representative, or a provider (member written consent is not required; however, physician certification is required).

An urgent request will be considered when any or all of these conditions apply:

- A delay in decision-making might jeopardize the member’s life, health, or ability to regain maximum function, or when supported by a provider with knowledge of the claimant’s medical condition;
- A delay in decision-making will subject the member to severe pain that cannot be managed without the care or treatment that is the subject of the appeal;
- The request concerns admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; and/or
- The request is concerning a concurrent review.

Requests from providers may be received either verbally or in a written format. Provider requests will be accepted as expedited requests. If a member submits the request, Highmark requires the provider to submit a **Physician Certification for Expedited Review** form. The Highmark Member Service Representative will send the form directly to the provider and it should be returned to Highmark immediately.

The appeals analyst will notify the provider and member of the decision by telephone and follow up with a written notification to the member and the provider **within seventy-two (72) hours** of receipt of the request. The expedited appeal decision letter will provide any additional appeal rights that are available.

**Note:** When an urgent appeal is filed, no additional internal appeals are available; this applies even if the member’s benefit plan has a two-level internal standard appeal process.
5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68)

Overview

The Pennsylvania Quality Health Care Accountability Protection Act (Act 68) is legislation enacted to protect the rights of those enrolled in managed care health plans. This act contains provisions that require health plans to establish procedures for member dissatisfactions, complaints, and grievances according to the legislative guidelines.

Any Highmark managed care member has the right to file a grievance for a medical necessity issue or a complaint for a benefit issue, as applicable, if they are not satisfied with decisions made by Highmark. Act 68 gives the provider the option of filing a grievance, but not a complaint, on behalf of the member as long as the provider obtains the member’s written consent. An Act 68 grievance can be submitted by or on behalf of a member even in situations in which the member is not financially liable for the services in question.

Definitions

A dissatisfaction is when a member expresses to the health plan, either verbally or in writing, that he or she is not satisfied with some aspect of the health care plan or delivery of health care services. A dissatisfaction that concerns the managed care network, benefits, quality of care, etc. becomes a formal complaint if the member, or the member’s authorized representative, requests a review of the matter.

A dissatisfaction becomes a grievance when the member, or the member’s authorized representative, files a written or verbal request for review of a denial of payment of a health care service on the basis of medical necessity and appropriateness.

Applicable products

The Act 68 grievance process described here applies to these Highmark managed care products in Pennsylvania, which includes commercial HMO products in the Western and Northeastern Regions.

Although the Act 68 Grievance process applies to HMO commercial plans, even those not governed by the Employee Retirement Income Security Act of 1974 (ERISA), self-insured employer groups are not obliged to comply with this process.

Children’s Health Insurance Program

Although Act 68 applies to the Pennsylvania Children’s Health Insurance Program (CHIP) managed care plans, the Commonwealth of Pennsylvania Department of Human Services (DHS) provisions include variations on these processes for CHIP.

Please refer to the Pennsylvania CHIP Complaints, Grievances, and External Review section of this unit for details of these processes for CHIP.
5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68), Continued

**Definition of a member grievance/appeal**

A member grievance/appeal is a process by which a member or member’s authorized representative (or provider on behalf of a member), with the written consent of the member, may file a written or verbal grievance regarding the denial of payment of a health care service on the basis of medical necessity and appropriateness. A grievance may be filed regarding a decision that:

1. Disapproves full or partial payment for a requested health care service; or
2. Approves the provision of a requested health care service for a lesser scope or duration than expected; or
3. Disapproves payment for the provision of a requested health care service but approves payment for the provision of an alternative health care service.

**Member’s written consent required**

A valid written consent, signed by the member, is required before a provider may proceed with the Act 68 grievance process. The Designation of an Authorized Representative form must be completed in its entirety. This form is available on the Provider Resource Center -- select FORMS, and then Miscellaneous Forms.

The member may not submit a separate grievance on the same issue without rescinding the consent in writing. The member may rescind consent at any time during the grievance process.

**Filing time frame and address**

The appeal must be filed no later than **one-hundred eighty (180) days** after receipt of the original denial notification.

The grievance may be submitted verbally or in writing with supporting documentation and the completed three-page Designation of an Authorized Representative form. Verbal grievances can be initiated by calling the Member Service telephone number on the back of the Member ID card. Written grievances can be sent to:

**Western & Northeastern Regions:**
- Highmark
- Member Grievance & Appeals Department
- P.O. Box 2717
- Pittsburgh, PA 15230-2717

**Central Region:**
- Highmark Blue Shield
- Attention: Grievance Committee
- P.O. Box 890174
- Camp Hill, PA 17089-0174

**Billing restrictions**

Once a health care provider assumes responsibility for filing a grievance, the provider may not bill the member or the member’s legal representative for services that are the subject of the grievance until the grievance process has been completed or the member rescinds consent.

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5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),
Continued

Letter to acknowledge receipt

An acknowledgement letter will be sent to the member and the provider filing on behalf of the member within five (5) business days from receipt of the grievance request.

The acknowledgement letter will include the following information:

- The right to submit additional information to support the appeal.
- Thirty (30) days for resolution.
- Confirmation that Highmark considers the matter to be a grievance rather than a complaint, and that the member, member’s representative, or provider may question the classification of complaints and grievances by contacting the Pennsylvania Department of Health.
- Description of the grievance process.
- Member may appoint a representative to act on his or her behalf at any time during the internal grievance process.
- The member, the member’s representative, or the provider filing on behalf of the member may review information related to the grievance upon request and also submit additional material to be considered by Highmark.
- A statement advising that the member or the member’s representative may request the assistance of a Highmark employee to assist in preparing the first level grievance.

Grievance review process – First Level

A provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will be assigned to review the documentation. The physician reviewer will be an individual who was not involved in any previous adverse benefit determination regarding the grievance and is not a subordinate of any individual involved. The physician reviewer will decide whether to uphold or overturn the initial determination.

The member and the provider filing on behalf of the member will be notified of the decision in writing within thirty (30) calendar days from receipt of the request. The decision letter will contain:

- A statement of the issue under review;
- The basis for the decision;
- The specific reasons for the decision;
- The scientific and clinical rationale for making the decision applying the terms of the plan to the member’s medical circumstances;
- Specific references to the plan’s provisions on which the decision is based or instructions on how to obtain the specific plan provisions; and
- An explanation of how to file a request for a second level review of the decision and the time frames for requesting a second level review.

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5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),
Continued

Requesting a second level grievance review

It is not necessary for written member consent for each level of the grievance process. A second level grievance request must be submitted in writing within forty-five (45) days from receipt of the first level grievance decision.

A hearing notification letter will be sent to the member and to the provider filing on behalf of the member at least fifteen (15) days prior to the hearing date. The notification advises the member and the provider filing on the member’s behalf that they have the right to attend and appear before the Second Level Review Committee or participate via phone.

Grievance review process – Second Level

The Second Level Review Committee will be made up of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for the services. The members of the Review Committee shall have the duty to be impartial in their review and decision. A provider in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment will be assigned. It will be an individual who was not involved in any previous adverse decisions regarding the grievance and will not be a subordinate of any individual previously involved.

The member and the provider filing on behalf of the member will be notified of the decision within thirty (30) days from receipt of the grievance request. The decision letter will include specifics of the grievance issue and reasons for the decision, as well as the procedure and time frames for filing a request for an external review. This letter will also advise whether the member/provider has third level external review rights (grandfathered groups), or independent external review rights (non-grandfathered groups).

Grievance review process – Third Level

The Third Level grievance review process applies to grandfathered groups only. Third level review requests must be submitted to Highmark within fifteen (15) days from receipt of the second level grievance decision. Within five (5) business days of receiving the request, Highmark will notify the Pennsylvania Department of Health (DOH) and request an assignment of an Independent Review Organization (IRO).

The DOH will randomly select an IRO to review the case and will notify the member and the provider filing on behalf of the member of the assigned IRO. Highmark will forward the case file to the IRO within fifteen (15) days of the request. Highmark will send the member and provider notification when the external grievance is filed, which will include a listing of all documents forwarded to the IRO. Any additional information must be submitted within fifteen (15) days of receipt of the notice that the external grievance was filed.

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5.5 GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68),
Continued

Grievance review process – Third Level (continued)

The IRO will assign a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment involved in the grievance and who was not involved in any previous decisions related to the grievance. The assigned IRO will review and issue a written decision within sixty (60) days of the filing of the request for an external grievance review. The written notification of the decision will be sent to the member, the provider filing on behalf of the member, Highmark, and the DOH. Highmark will implement the IRO’s decision within the time frame specified by the IRO.

If the external grievance is requested by a provider, the Plan and the provider must each establish an escrow account in the amount of half the anticipated cost of the review. If the IRO’s decision in an external grievance review filed by a provider is against the provider in full, the provider shall pay the fees and costs associated with the external grievance. If the IRO’s decision is against the Plan in full or in part, the Plan will pay the fees and costs associated with the external grievance review.

Independent external review applies to non-grandfathered groups.
Independent external review requests must be submitted to Highmark within four (4) months from receipt of the second level decision letter. Within five (5) business days from Highmark’s receipt of the external review request, a preliminary review will be conducted to determine whether:

- The member is or was covered at the time the health care item or service was requested or, in the case of retrospective review, was covered at the time the service was provided.
- The adverse determination does not relate to the member’s failure to meet the requirements for eligibility under the terms of the plan.
- The member has exhausted the plans internal appeal process, unless the member is not required to exhaust the internal appeal process
- The member/member’s representative has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, Highmark will issue a written notification to the member and the provider filing on behalf of the member. If the request is not complete, the notification will describe the necessary information needed to proceed.

Highmark will assign an Independent Review Organization (IRO) who will review all information and make a decision within forty-five (45) days after the IRO receives the request. The IRO will provide a written decision to the member, the provider filing on behalf of the member, and Highmark.
5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER
(PA ACT 68)

Overview

A managed care member may request an expedited review at any stage of the Act 68 grievance review process if the member’s life, health, or ability to regain maximum function would be placed in jeopardy by delay under the time frames of the standard review process.

As in the standard grievance process, the member has one-hundred eighty (180) days from the notification of an adverse benefit determination to file an expedited grievance. Act 68 also gives the provider the option of filing an expedited grievance on behalf of the member.

Note: When an expedited grievance is requested, an additional level of internal appeal is not available.

Expedited grievance defined

An expedited grievance is a request for an expedited review of an initial denial for a medical, pharmaceutical, or behavioral health service based on medical necessity and appropriateness when:

- A delay in decision-making might jeopardize the member’s life, health, or ability to regain maximum function based on a prudent layperson’s judgment and confirmed by the treating practitioner; or
- In the opinion of a practitioner with knowledge of the member’s medical condition, a delay would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request; or
- It is concerning the admission, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility; or
- it is concerning a concurrent review.

Expedited grievance process

Requests from providers may be either verbal or in a written format and will be accepted as expedited requests. If a member submits the same type of request, Highmark requires the provider to submit a Physician Certification for Expedited Review Form for verification that the service requires an expedited review. The form is sent directly to the provider and should be returned to Highmark immediately.

Expedited grievances will follow the Second Level review process (see previous section on the standard grievance process), with verbal and written notification of the decision to the member and provider within forty-eight (48) hours from receipt of the request.

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5.5 EXPEDITED GRIEVANCE: FILING ON BEHALF OF A MEMBER (PA ACT 68), Continued

Expedited grievance process (continued)

It is the responsibility of the member, or the provider filing on behalf of the member, to provide information to Highmark in an expedited manner to allow Highmark to conform to the requirements of the expedited process. The hearing may be held by telephone if the member and/or provider on behalf of the member cannot be present in the short time frame. All information presented at the hearing is read into the record.

If Highmark cannot provide a copy of the report of the same or similar specialist to the member/provider prior to the expedited hearing, Highmark may read the report into the record at the hearing and provide the member and the provider filing on behalf of the member with a copy of the report at that time.

The written decisions to the member and provider on behalf of the member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

Expedited external review

For grandfathered groups, the member or provider on behalf of the member has two (2) business days from the receipt of the expedited grievance decision to contact Highmark to request an expedited external review.

Highmark will submit a request for an expedited external review to the Pennsylvania Department of Health (DOH) within twenty-four (24) hours of receipt of the request. The DOH will assign an Independent Review Organization (IRO) within one (1) business day of receiving the request for an expedited review. Highmark will then transfer a copy of the case file to the IRO within one (1) business day after being assigned to an IRO. The IRO will have two (2) business days following the receipt of the case file to make a decision.

For non-grandfathered groups, the written notification of the expedited review decision will state the basis of the decision, including any clinical rationale and the procedure for obtaining an expedited independent external review. The member or provider on behalf of the member has four (4) months from the receipt of the expedited grievance decision to request an expedited external review.
5.5 PENNSYLVANIA CHIP COMPLAINTS, GRIEVANCES, AND EXTERNAL REVIEW

Introduction
The Pennsylvania Quality Health Care Accountability Protection Act (Act 68), legislation enacted to protect the rights of those enrolled in managed care health plans, applies to Pennsylvania’s Children’s Health Insurance Program (CHIP) managed care plans.

In addition, the Commonwealth of Pennsylvania Department of Human Services (DHS) also provides these protections for CHIP with provisions that require some variations from the processes for our other managed care plans.

Under Pennsylvania’s CHIP, an enrollee or enrollee’s representative, which may include the enrollee’s provider, may file a complaint or grievance. The representative must have the enrollee’s written authorization to be involved and/or act on the enrollee’s behalf.

This section will outline the complaint and grievance processes for Highmark CHIP enrollees. These processes apply to Highmark CHIP HMO plans in the Western and Northeastern Regions of Pennsylvania and to CHIP PPO Plus plans in the Central Region.

Complaint defined
A Complaint is a dispute or objection regarding a participating provider or the coverage, operations, or management policies of a managed care organization (MCO), which has been filed with the MCO or with the Pennsylvania Department of Health (PADOH) or the Pennsylvania Insurance Department (PID). The term does not include a Grievance.

Complaints include, but are not limited to the following:
1. Denial because the requested service or item is not a covered benefit;
2. Failure of the MCO to meet the required time frames for providing a service or item;
3. Failure of the MCO to decide a Complaint or Grievance within the specified time frames;
4. Denial of payment by the MCO after a service or item has been delivered because the service or item was provided without authorization by a Provider not enrolled in the CHIP;
5. Denial of payment by the MCO after a service or item has been delivered because the service or item is not a covered service or item for the enrollee.

Continued on next page
5.5 PENNSYLVANIA CHIP COMPLAINTS, GRIEVANCES, AND EXTERNAL REVIEW, Continued

Filing a first level Complaint

An enrollee or the enrollee’s representative, which may include the enrollee’s provider, with proof of the enrollee’s written authorization for the representative to be involved and/or act on the enrollee’s behalf, can file a first level Complaint either orally or in writing.

If the first level Complaint disputes one of the following, the Complaint must be filed within sixty (60) calendar days from the date of the incident complained of or the date the enrollee receives written notice of a decision:

1. A denial because the service or item is not a covered service;
2. The failure of Highmark to provide a service or item in a timely manner;
3. The failure of Highmark to decide a Complaint or Grievance within the specified time frames;
4. A denial of payment after the service or item has been delivered, or the item was provided without authorization by a provider not enrolled in CHIP;
5. A denial of payment after the service or item has been delivered because the service or item is not a covered service for the enrollee; or
6. A denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

For all other Complaints, there is no time limit for filing a first level Complaint.

First level complaint process

Upon receipt of the Complaint, Highmark will send the enrollee, and the enrollee’s representative if applicable, an acknowledgment letter. In addition, the enrollee will be given at least seven (7) calendar days advance written notice of the first level Complaint review date.

If the enrollee cannot appear in person at the first level Complaint review meeting, Highmark will provide an opportunity for the enrollee to communicate by telephone or videoconference.

The first level Complaint review committee will include one or more Highmark employees who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint. If the Complaint involves a clinical issue, the review committee will include a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question.

Continued on next page
First level complaint process (continued)

The first level Complaint review committee will complete its review of the Complaint as expeditiously as the enrollee’s health condition requires. A written notice of the first level Complaint decision will be sent to the enrollee, enrollee’s representative, service provider, and prescribing provider, if applicable, within thirty (30) calendar days from the date Highmark received the Complaint, unless the time frame for deciding the Complaint has been extended up to fourteen (14) calendar days at the request of the enrollee.

If the Complaint involves one of the six disputes listed above for which a Complaint must be filed within sixty (60) calendar days, the enrollee or enrollee’s representative may file a request for an External Review within fifteen (15) calendar days from the mail date of Highmark’s written notice of the first level Complaint decision.

For all other Complaints for which an external review is not available, the enrollee or enrollee’s representative may file a second level Complaint either in writing or orally within forty-five (45) calendar days from the date the enrollee received written notice of the first level Complaint decision.

Second level Complaint process

Upon receipt of a second level Complaint, Highmark will send the enrollee, and the enrollee’s representative if applicable, a second level Complaint acknowledgment letter. Highmark will give the enrollee at least fifteen (15) calendar days advance written notice of the second level Complaint review date.

If the enrollee cannot appear in person at the second level Complaint review meeting, Highmark will provide an opportunity for the enrollee to communicate by telephone or videoconference.

The second level Complaint review committee for non-clinical issues will be made up of three (3) or more individuals who were not involved in and are not the subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

If the second level Complaint involves a clinical issue, the second level Complaint review committee will also include a licensed physician in the same or similar specialty that typically manages or consults on the service or item. The licensed physician will decide the second level Complaint. In addition, at least one-third of the second level Complaint review committee will not be employees of Highmark or a related subsidiary or affiliate.
The second level Complaint review committee will complete its review as expeditiously as the enrollee’s health condition requires. A written notice of the second level Complaint decision will be sent to the enrollee, enrollee’s representative, service provider, and prescribing provider, if applicable, within forty-five (45) calendar days from the date Highmark received the second level Complaint.

The enrollee or enrollee’s representative, which may include the enrollee’s provider, may file a request in writing for an external review of the Complaint decision with either the PADOH or PID within fifteen (15) calendar days of receiving Highmark’s second level Complaint decision.

When requests for external review are filed, Highmark will transmit all records from the Complaints review to either the PADOH or PID, as per requested, within thirty (30) days from the PADOH or PID request. The enrollee, provider, or Highmark may submit additional materials related to the Complaint.

The PADOH and PID will determine the appropriate agency for the review.

A request for an expedited review of a Complaint may be filed in writing, by fax, orally, or by email. An expedited review of a Complaint will be conducted if Highmark determines that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, or if an enrollee or enrollee’s representative, with proof of the enrollee’s written authorization for the representative to be involved and/or act on the enrollee’s behalf, provides Highmark with a certification from the enrollee’s provider that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process. The certification must include the provider’s signature.

If the provider certification is not included with the expedited Complaint request and Highmark cannot determine, based on the information provided, that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Complaint process, Highmark will inform the enrollee that the provider must submit a certification. Highmark will make a reasonable effort to obtain the certification from the provider; however, if it is not received within seventy-two (72) hours of the enrollee’s request for expedited review, Highmark must decide the Complaint within the standard time.
5.5 PENNSYLVANIA CHIP COMPLAINTS, GRIEVANCES, AND EXTERNAL REVIEW, Continued

Filing an expedited Complaint (continued)
frames as set forth in this unit, unless the time frame for deciding the Complaint has been extended up to fourteen (14) calendar days at the request of the enrollee. Highmark will give the enrollee prompt oral notice that the Complaint will be decided within the standard time frame and send a written notice within two (2) business days of the decision to deny expedited review.

Expedited Complaint process
The expedited review of a Complaint review will be conducted by a Complaint review committee that includes a licensed physician in the same or similar specialty that typically manages or consults on the service or item in question. The members of the expedited Complaint review committee will not have been involved or will not be subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Complaint.

Highmark will issue the decision resulting from the expedited review in person or by phone to the enrollee, the enrollee’s representative, service provider, and prescribing provider, if applicable, within either forty-eight (48) hours of receiving the provider certification or within seventy-two (72) hours of receiving the enrollee’s request for an expedited review, whichever is shorter, unless the time frame has been extended by up to fourteen (14) days at the request of the enrollee. In addition, Highmark will mail written notice of the decision to the enrollee, the enrollee’s representative, the service provider, and prescribing provider, if applicable, within two (2) business days of the decision.

Expedited external Complaint
The enrollee or the enrollee’s representative may file a request for an expedited external review within fifteen (15) calendar days from the mail date of Highmark’s written notice of the expedited Complaint decision. The request for an expedited external Complaint review may be filed in writing, by fax, orally, or by email.

Grievance defined
A Grievance is a request to have an MCO or utilization review entity reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. The term does not include a Complaint.

A Grievance may be filed regarding an MCO’s decision to:
1. Deny, in whole or in part, payment for a service or item;
2. Deny or issue a limited authorization of a requested service or item including the type or level of service or item;

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3. Reduce, suspend, or terminate a previously authorized service or item;
4. Deny the requested service or item but approve an alternative service or item; and
5. Deny a request for a Benefit Limit Exemption (BLE).

In order for the provider to represent the enrollee in the conduct of a Grievance, the provider must obtain the written consent of the enrollee and submit the written consent with the Grievance.

Although the provider may obtain the enrollee’s written consent at the time of treatment, the provider cannot require an enrollee to sign a document authorizing the provider to file a Grievance as a condition of treatment.

If an enrollee consents to the filing of a Grievance by a provider, the enrollee may not file a separate Grievance. The enrollee may rescind consent at any time throughout the process upon written consent to Highmark and the provider.

The written consent must include:

- Name and address of the enrollee, the enrollee’s date of birth and identification number;
- The name, address, and relationship to the enrollee of the person who signed the consent if the enrollee is a minor or is legally incompetent;
- The name, address, and Highmark identification number of the provider to whom the enrollee is providing consent;
- Highmark’s name and address (the MCO to which the Grievance will be submitted);
- An explanation of the specific service or item that was provided or denied to the enrollee to which the consent will apply;
- The following statement: “The enrollee or the enrollee’s representative may not submit a Grievance concerning the service or item listed in this consent form unless the enrollee or the enrollee’s representative rescinds consent in writing. The enrollee or enrollee’s representative has the right to rescind consent at any time during the Grievance process.”;
- The following statement: “The consent of the enrollee or the enrollee’s representative shall be automatically rescinded if the provider fails to file a Grievance or fails to continue to prosecute the Grievance through the review process.”;

Continued on next page
Written consent of the enrollee (continued)

- The following statement: “The enrollee or enrollee’s representative, if the enrollee is a minor or is legally incompetent, has read, or has been read, this consent form, and has had it explained to his/her satisfaction. The enrollee or the enrollee’s representative understands the information in the enrollee’s consent form.”; and
- The dated signature of the enrollee, or the enrollee’s representative, and the dated signature of a witness.

Grievance process

An enrollee, or the enrollee’s representative, can file a Grievance either orally or in writing. The Grievance must be filed within sixty (60) calendar days from the date the enrollee receives written notice of a decision. Upon receipt of the Grievance, Highmark will send the enrollee, and the enrollee’s representative, a Grievance acknowledgment letter.

The Grievance review will be conducted by a Grievance review committee made up of three (3) or more individuals who were not involved in and are not subordinates of an individual involved in any previous level of review or decision-making on the issue that is the subject of the Grievance. At least one-third of the Grievance review committee will not be employees of Highmark or a related subsidiary or affiliate.

The enrollee will be given at least fifteen (15) calendar days advance written notice of the review date. The Grievance review committee will complete its review of the Grievance as expeditiously as the enrollee’s health condition requires.

A written notice of the Grievance decision will be sent to the enrollee, enrollee’s representative, service provider, and prescribing provider, if applicable, within thirty (30) calendar days from the date Highmark received the Grievance, unless the time frame for deciding the Grievance has been extended by up to fourteen (14) calendar days at the request of the enrollee.

External Grievance process

The enrollee or enrollee’s representative may file a request for an external review within fifteen (15) calendar days from the mail date on the written notice of the Grievance decision. Within five (5) business days of receipt of the request for an external Grievance review, Highmark will notify the enrollee, the enrollee’s representative if one is designated in writing, the provider if the provider filed the request for the external Grievance review, and the PADOH, if appropriate, that the request for external review has been filed.
External Grievance process (continued)

Within two (2) business days from receipt of the request for an external Grievance review, the PADOH will randomly assign a certified review entity (CRE) to conduct the review. **Within fifteen (15) calendar days** from receipt of the enrollee’s request for an external Grievance review, Highmark will forward all documentation regarding the Grievance decision, including all supporting information, a summary of applicable issues, and the basis and clinical rationale for the Grievance decision, to the CRE conducting the external Grievance review. The enrollee or the enrollee’s representative, or the enrollee’s provider, may supply additional information to the CRE within that fifteen (15) calendar days’ time frame. Copies must also be provided to Highmark at the same time.

**Within sixty (60) calendar days** from the filing of the request for the external Grievance review, the CRE conducting the external Grievance review must issue a written decision to Highmark, the enrollee, the enrollee’s representative, and the provider (if the provider filed the Grievance with the enrollee’s consent) that includes the basis and clinical rationale for the decision.

The external Grievance decision may be appealed by the enrollee, the enrollee’s representative, or the provider to a court of competent jurisdiction **within sixty (60) calendar days** from the date the enrollee receives notice of the external Grievance decision.

**Expedited Grievance process**

Highmark will conduct an expedited review of a Grievance if it is determined that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process, or if an enrollee or enrollee’s representative provides Highmark with a certification from the enrollee’s provider that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. The certification must include the provider’s signature.

A request for expedited review of a Grievance may be filed in writing, by fax, by email, or orally. The expedited review process is bound by the same rules and procedure as the Grievance review process with the exception of time frames, which are modified as specified in this section.

If the provider certification is not included within the request for an expedited review and Highmark cannot determine, based on the information provided, that the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance
5.5 PENNSYLVANIA CHIP COMPLAINTS, GRIEVANCES, AND EXTERNAL REVIEW, Continued

**Expedited Grievance process** (continued)

If Highmark’s review or the External Review reverses a decision to deny, limit, or delay a service or item that was not furnished during the Complaint, Grievance, or External Review process, Highmark will authorize or provide the disputed service or item as expeditiously as the enrollee’s health condition requires but no later than **seventy-two (72) hours** from the date it receives notice that the decision was reversed.

The enrollee or the enrollee’s representative may file a request for an expedited external Grievance review **within fifteen (15) calendar days** from the mail date on Highmark’s written notice of the expedited Grievance decision.

Continued on next page
If Highmark’s review or the External Review reverses a decision to deny authorization of a service or item, and the enrollee received the disputed service or item during the Complaint, Grievance, or External Review process, Highmark will provide coverage for the service or item the enrollee received.
5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE (PA ACT 62)

Overview of autism mandate

Pennsylvania Act 62 requires private insurers to provide coverage for medically necessary diagnostic assessment and treatment of autism spectrum disorders (ASD) to covered individuals under twenty-one (21) years of age.

This mandate applies to any fully insured health insurance policy offered, issued, or renewed on or after July 1, 2009, to groups of fifty-one (51) or more employees. The mandate also applies to any contract executed on or after July 1, 2009, by the Children’s Health Insurance Program (CHIP).

Expedited internal review process

If the Act 62 ASD mandate is applicable, a covered individual or an authorized representative is entitled to an expedited internal review process upon denial or partial denial of a claim for diagnostic assessment or treatment of ASD, followed by an expedited independent external review process established and administered by the Pennsylvania Insurance Department. A member or authorized representative also has the option to choose the standard appeal process.

The request for an expedited internal review may be submitted verbally or in writing. The mandated expedited review process applies to both pre-service and post-service denials for diagnostic assessment or treatment of ASD.

The expedited internal appeal will be reviewed by the Second Level Review Committee as set forth under Article XXI (Act 68). The Second Level Review Committee is made up of three (3) or more individuals who did not previously participate in the decision to deny coverage or payment for health care services. The committee shall include a licensed physician or an approved licensed psychologist in the same or similar specialty as that which would typically manage or consult on the health care service in question. The members of the review committee shall have the duty to be impartial in their review and decision.

Verbal and written notification of the decision will be issued to you and the member within forty-eight (48) hours from receipt of the request. The written decision to the member, member’s representative, or provider on behalf of the member will state the basis for the decision, including any clinical rationale, and the procedure for obtaining an expedited external review.

The member, member’s representative, or provider on behalf of the member has two (2) business days from receipt of the expedited grievance decision to request an expedited external review.

Continued on next page
5.5 EXPEDITED REVIEW PROCESS UNDER THE AUTISM MANDATE
(PA ACT 62), Continued

**Expedited external review**

If an adverse determination is upheld by the internal review committee, the covered individual or an authorized representative is then entitled to an expedited external independent review process administered by the Pennsylvania Insurance Department.

An insurer or covered individual or an authorized representative may appeal an order of an expedited independent external review to a court of competent jurisdiction.

**Verify coverage**

To determine if a member is covered under the autism mandate, you can verify the member’s coverage using the *Eligibility and Benefits Inquiry* function in NaviNet® or by calling the Provider Service Center.
5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF

Overview

Providers are entitled to appeal a medical necessity denial decision and are informed of this right at the time of the denial decision. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The processes as described here apply to members with coverage under one of Highmark’s Medicare Advantage products.

When the provider can appeal on its own behalf

A provider can make use of this provider appeal process when all of the following are true:

• The provider is contracted with Highmark
• The member has coverage under a Medicare Advantage product
• The services in question have a medical necessity denial determination, including denials for services considered experimental/investigational or cosmetic in nature
• The member is held financially harmless
• The provider seeks a resolution in order to obtain payment for the services

Types of appeals

Expedited appeals and standard appeals are available to the provider for medical necessity denial determinations.

An expedited appeal is a formal review of an initial adverse medical necessity determination. It can be requested when a delay in decision-making may seriously jeopardize the member’s life, health, or ability to regain maximum function. Highmark reserves the right to determine whether the request meets the criteria for an expedited appeal.

A standard appeal is a formal review of the initial adverse medical necessity determination in which the conditions for expedited appeal are not met. Standard appeal can also be used as a secondary appeal level when a denial has been upheld under the expedited appeal process.

Member expedited review rights

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determinations and appeals. Members of all Highmark Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member’s health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process. In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

Continued on next page
5.5 MEDICARE ADVANTAGE: PROVIDER APPEALING ON OWN BEHALF, Continued

Although these processes are largely member-driven, the provider may represent the member and initiate the expedited review. Highmark reserves the right to determine whether the request meets the criteria for an expedited provider appeal. Each appeal is processed in a manner consistent with the clinical urgency of the situation.

The provider must indicate either verbally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The provider need not be appointed as the member's authorized representative in order to make the request.

Requests for medical records

Providers may be contacted by a Highmark staff member or physician reviewer to supply a copy of the member’s medical records in the case of an expedited review. If so, you must supply the records immediately.

Additionally, if you are contacted for information by a physician reviewer about an expedited appeal, you must return his or her call by 8 a.m. the next day. Failure to do so could result in corrective action and/or sanctioning.

IMPORTANT: Appeals related to naviHealth denials

A denial of post-acute care services will be issued by naviHealth, similar to the approval of services. naviHealth generates the notification of denial of coverage to both the provider and to the patient. If requested, naviHealth also offers a peer-to-peer clinical conversation with the naviHealth Medical Director.

Any appeal of the preservice or concurrent denial of services rendered by naviHealth will be handled by Highmark, just as appeals are currently handled. Highmark will continue to handle appeals when the member has not yet been admitted to a post-acute care facility or when the member is still inpatient. Appeals for these situations should be initiated by contacting Highmark Medicare Advantage Expedited Appeals at 1-800-485-9610.

naviHealth will handle appeals after the member has been discharged from the post-acute care facility and a denial has been received. naviHealth can be contacted for post service provider appeals as follows:

- Phone 1-844-838-0929; Fax 1-855-893-5963
- Address for appeals: naviHealth
  Attention: Provider Appeals
  10 Cadillac Drive, Suite 400
  Brentwood, TN 3702

Continued on next page
This provider appeal process would apply in situations when a decision needs to be made in an urgent manner for a member with Highmark Medicare Advantage coverage. This includes appeals of initial denial determinations prior to services being rendered and appeals of denial decisions for continued services following a concurrent review.

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members:

<table>
<thead>
<tr>
<th>EXPEDITED APPEALS</th>
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<tbody>
<tr>
<td><strong>How to Initiate</strong></td>
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<tr>
<td>Requests for expedited review can be initiated either verbally or in writing.</td>
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<tr>
<td>Call the Medicare Advantage Expedited Review Department at 1-800-485-9610;</td>
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<td>or</td>
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<td>Fax the information to 1-800-894-7947;</td>
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<td>or</td>
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<td>Submit all pertinent medical and other information to:</td>
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<td>Medicare Advantage Expedited Review Department</td>
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<td>P.O. Box 534047</td>
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<tr>
<td>Pittsburgh, PA 15253-5073</td>
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<tr>
<td><strong>When to Initiate</strong></td>
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<tr>
<td>Prior to rendering services, continuing services, or prior to the member’s discharge from the facility; but within sixty (60) days from receipt of the denial notification.</td>
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<tr>
<td><strong>Decision Time Frame</strong></td>
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<td>As expeditiously as the member’s health requires, but not to exceed seventy-two (72) hours from receipt of the appeal request. The 72-hour time frame may be extended by up to fourteen (14) calendar days if the member requests or if additional information is needed.</td>
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Continued on next page
This provider appeal process applies to initial denial determinations for services that have already been rendered, including denials resulting from retrospective review of services rendered without the required authorization.

This process would also apply to appeals for initial preservice denial determinations in non-urgent situations and as a secondary appeal level when an initial denial has been upheld in the expedited appeal process.

The table below explains how the standard review process for Medicare Advantage members works:

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<tr>
<th>STANDARD APPEALS</th>
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<td><strong>How to Initiate</strong></td>
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<td><strong>PENNSYLVANIA</strong></td>
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<tr>
<td><strong>When to Initiate</strong></td>
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<tr>
<td><strong>Decision Time Frame</strong></td>
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</table>
5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER

Overview

Members of a Medicare Advantage plan have a right to file an appeal if their plan will not pay for, does not allow, or stops or reduces a course of treatment that they believe should be covered or provided.

Ordinarily, it is the member or the member’s family who files an appeal if a requested medical service is not authorized; however, the member might ask a provider or other representative to file an appeal on his or her behalf. A provider can do so only if the member would be financially liable for the services.

Representative statement

The Centers for Medicare & Medicaid Services (CMS) provides an Appointment of Representative (AOR) form (#CMS 1696). This form is also available on the CMS website at:


The member is not required to use the CMS form. They may write their own representative statement appointing a provider or other individual as an authorized representative. The written authorization must contain the following criteria:

- Member’s name, Medicare number, address, and telephone number
- Representative’s name, address, telephone number, and professional status or relationship to the member
- A statement signed and dated by the member or the individual holding the member’s power of attorney authorizing the named person to act as the member’s representative in appeal of the denial decision, and acknowledging that he or she understands that personal medical information may be disclosed to this representative
- A statement signed and dated by the appointed representative confirming acceptance of their appointment and agreeing to waive the right to charge a fee for representation
- A statement signed and dated by the provider waiving their right to collect payment from the member for items or services at issue

EXCEPTION: In preservice denial situations that meet the criteria for an expedited request, the member’s ordering provider (either contracting or non-contracting) can act as the member’s representative without a signed representative statement.

Types of appeals

Two types of appeals are available to the member or to the facility acting as the member’s appointed representative:

- Expedited appeal
- Standard appeal

Continued on next page
5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER, Continued

Expedited appeals

If the member or the member’s authorized representative believes that following the standard appeal process would seriously jeopardize the member’s life, health, or ability to regain maximum function, an expedited appeal can be requested. The health plan reserves the right to determine whether the request meets the criteria for an expedited appeal.

Highmark will make a decision on an expedited appeal as expeditiously as the member’s health requires, but no later than seventy-two (72) hours from receipt of the request.

Standard appeals

Standard member appeals, including those filed on the member’s behalf by a facility, are those that do not meet the criteria for an expedited appeal as determined by the health plan, or those in which the member’s health would not be jeopardized by the standard appeal time frame.

Standard appeals are processed as expeditiously as the member’s health requires, but no later than thirty (30) calendar days from receipt of the request.

Option for inpatient discharge decisions

When an inpatient in a hospital, a Medicare Advantage member has another appeal option if he or she disagrees with a discharge decision. An immediate review by the Quality Improvement Organization (QIO) can be requested.

Note: For more information on this QIO appeal process, please see Chapter 5.3: Medicare Advantage.

Non-participating providers

A non-participating provider can file a standard appeal on behalf of a Medicare Advantage member for post-service denials only if it submits a Waiver of Liability statement with the appeal. The waiver states that the provider will not bill the member regardless of the outcome of the appeal.

Providers that do not participate with Highmark’s Medicare Advantage products should follow the standard appeals process as outlined below when appealing a post-service denial.

Continued on next page
### 5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER, Continued

**Appeal processes** The table below explains the expedited and standard appeal processes for Medicare Advantage.

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<thead>
<tr>
<th>EXPEDITED APPEALS</th>
<th>STANDARD APPEALS</th>
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<tbody>
<tr>
<td><strong>How to Initiate</strong></td>
<td><strong>Submit all pertinent information to:</strong></td>
</tr>
</tbody>
</table>
| Call the Medicare Advantage Expedited Review Department at **1-800-485-9610.**  
**or**  
Fax the request to **1-800-894-7947.**  
**or**  
Submit all pertinent information to:  
Medicare Advantage Expedited Appeals Department  
P.O. Box 534047  
Pittsburgh, PA 15253-5073 | Highmark Appeals and Grievance Department  
P.O. Box 534047  
Pittsburgh, PA 15253-5047  
**or**  
Fax the information to the Appeals department at **717-635-4209.** |

<table>
<thead>
<tr>
<th><strong>When to Initiate</strong></th>
<th><strong>Within sixty (60) days</strong> from receipt of the denial notification (if good cause is shown, written requests can be accepted after 60 days).</th>
</tr>
</thead>
</table>
| **Prior authorization denials:**  
Before rendering the service.  
**Concurrent review denials:**  
Before discharge or continuation of treatment. |                                                                                                                                   |

| **Decision Time Frame** | **As expeditiously as the member’s health requires, but not to exceed seventy-two (72) hours** from receipt of the request.  
**Fourteen (14) day extension**  
The health plan or the facility filing on behalf of the member may request extensions of up to **fourteen (14) calendar days** for rendering a decision.  
Requests for extension must be in the best interest of the member. The health plan must justify the need for the extension and notify the member in writing. |
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<tbody>
<tr>
<td><strong>As expeditiously as the member’s health requires, but no later than thirty (30) calendar days</strong> from the receipt of the appeal request.</td>
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</table>

**If a denial on an appeal is upheld** When the health plan renders an adverse decision on an appeal, Highmark automatically forwards the case to the CMS independent review agency and sends a written notification to the member for Medicare Advantage (Part C).  
**Note:** For Part D prescription drug coverage, the member or provider must request an appeal through the CMS appeals contractor.  
The appeals contractor may request additional information. In such cases, a Highmark Medicare Advantage appeals staff member may contact you for additional information. If you are contacted, please respond to the request immediately.

*Continued on next page*
5.5 MEDICARE ADVANTAGE: APPEALS ON BEHALF OF A MEMBER, Continued

If a denial on an appeal is upheld (continued)

If the CMS independent review agency also renders an adverse decision, the member has the right to initiate further action. The denial communication from the independent review agency includes information about this option.
5.5 PROVIDER APPEAL RIGHTS FOR PRESCRIPTION DRUG BENEFITS

Overview
If you are a participating provider with Highmark and you disagree with the decision to deny authorization or payment of a prescription drug for a Highmark Commercial member, you have a right to appeal that decision.

NOTE: This section does not apply to Medicare Part D prescription drug coverage.

Expedited appeals
Expedited appeals are available when the application of the standard appeal time frame could seriously jeopardize the member’s life, health, or ability to regain maximum function, or would subject the member to severe pain that cannot be managed without the care or treatment which is the focus of the appeal.

To request an expedited appeal, please contact Highmark’s Prescription Drug Department by fax at 1-866-240-8123; or by calling 1-800-600-2227.

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within two (2) business days of receipt of your appeal request.

Standard appeals
If you are not eligible for an expedited appeal, or if your expedited appeal resulted in an adverse determination, you may initiate a standard appeal.

To request a standard appeal, please contact the Highmark Prescription Drug Department by fax at 1-866-240-8123; or by calling 1-800-600-2227.

You will be permitted to provide additional information over the telephone, by fax, or by other appropriate means. A decision will be rendered within thirty (30) days of receipt of your appeal request.

Appeal requests can also be mailed to:
Highmark
P.O. Box 279
Pittsburgh, PA 15230-2717
Attn: Provider Appeal Review Committee

Appeals on behalf of a member
Providers can initiate appeals on behalf of the member with the member’s written consent. However, if the member gives the provider consent to file an appeal on his or her behalf, then the member is not permitted to file a separate appeal. Member appeal requests must be received within one hundred eighty days (180) of member receipt of denial.

Continued on next page
5.5 PROVIDER APPEAL RIGHTS FOR PRESCRIPTION DRUG BENEFITS, Continued

Appeals on behalf of a member (continued)

When submitting appeal requests on behalf of a member, you will be asked to provide the following information:

- The member’s name, the patient’s name, and the group policy number
- The actual drug for which payment was denied and the date of service
- The reasons why you feel the drug should be provided
- Any available clinical information to support your appeal
- Signed consent of member (patient) and provider

Additional information related to member appeal rights will be provided when an appeal request is received.

Questions?

If you have questions about your right to appeal, or about how to file an appeal, please call the Highmark Prescription Drug Department at 1-800-600-2227 between 8:30 a.m. and 4:30 p.m., Monday through Friday.